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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned (Disagree)

☐ Partially Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured at work on X. X sustained a X. The diagnosis was superior glenoid labrum lesion of left shoulder, initial encounter, of left shoulder (X).On X, X was evaluated by X, X progress visit. X attended therapy evaluation on X for evaluation of X. X had attended X. Overall, X reported about X improvement since X. X was able to reach higher to get objects from the cabinets. X could lift heavier objects at home such as detergent bottles and milk. X still had mild to moderate pain at times (X). X still had pain when sleeping on the left side. X was using X as needed. X still had to be careful when having underarm because X could not fully flexion X left arm. X still had some difficulty hooking X bras and reaching behind X back. X would see the surgeon again at the end of X. Treatment to date had focused on X chief complaints of left shoulder pain, weakness, and stiffness. X reported pain at left shoulder was X at best, X at worst and ongoing pain was X. The ongoing level of functioning was as follows: X had moderate difficulty in activities of daily living (ADL), reaching, house chores and sleeping. Left shoulder examination revealed active range of motion (ROM) in flexion was X degrees, extension X degrees, abduction X degrees, internal rotation X degrees and external rotation was X degrees. The muscle strength in flexion was X with pain, X in extension, X in abduction, internal / external rotation. The grip strength was X pounds. There was tenderness to superior / anterior left shoulder, left upper trapezius, and rhomboids. On assessment, X was X weeks status post left shoulder labral repair. X demonstrated improving ROM, strength, postural awareness, and functional endurance. X was reporting less pain with ADLs. X still had residual weakness and pain when lifting above the head, behind X back, and out laterally. Continued X. X rehabilitation potential was good. X discharge prognosis was good. An MRI of left shoulder dated X revealed X. Treatment to date included X. Per a utilization review / Peer Review Report dated X by X, DO, the request for X was denied. Rationale: “"ODG by MCG Shoulder (Updated: X) Physical Therapy (PT) for Shoulder Conditions Recommended (generally)R Recommended based on limited evidence. ODG Criteria ODG Physical Therapy Guidelines - Allow for fading of

treatment frequency (from up to X visits per week to X or less), plus active self-directed home PT. Superior glenoid labrum lesion: Post-surgical treatment (labral repair/SLAP lesion): X visits over 14 weeks" The patient had status X. The patient's note indicates X improvement since starting therapy, with improvements in activities of daily living but continued limitations with strength maneuvers and residual weakness with lifting above the head. However, the request exceeds ODG recommendations. Therefore, the request for X is non-certified. "In a letter dated X, X, PT wrote, "X has been receiving X. X was recently denied more X. I am writing this letter to further explain why X is medically necessary. At X recent progress note (X) X reported that X is about X improved since starting X. X is still having difficulty with reaching overhead, hooking X bra, lifting heavy objects, sleeping on X L side, and shaving under X L arm. X is still having pain X at times. X has improved X ROM and strength throughout physical therapy, but X still has deficits compared to X unaffected side. The request for X was denied for X. X still needs X. X has worked hard to set to this point but is still limited functionally. X has been very compliant with attendance and home exercise program. Please reconsider your decision and allow X to make a full recovery from X surgery. "Per a reconsideration review determination letter dated X and a Peer Review Report dated X by X, MD, the appeal request for X was denied. Rationale: "Based on the provided documentation, the claimant presented s/p left shoulder arthroscopy, labral repair; application abduction pillow sting dated X. The physical examination revealed unremarkable. The claimant has been diagnosed with left shoulder labral tear with paralabral cyst Per ODG guidelines, "Superior glenoid labrum lesion: Postsurgical treatment (labral repair/SLAP lesion): X." A prior denial by Dr. X dated X, was denied on the basis the claimant has completed X. However, X exceeds guidelines recommendations. It is noted the claimant has completed X. However, there was no recent orthopedic note with a full examination provided to support the request. As such, the medical necessity of this request has not been established. Therefore, the request for an APPEAL X is not medically necessary. "The requested X is not medically necessary. The records reflect that the patient has already completed X. The X request would exceed the recommended guidelines. In addition, no records have been provided from the treating provider to explain the rationale for the X to explain any extending circumstances which would supersede the recommended guidelines. As such, no new information has

been provided which would overturn the previous denials. X is not medically necessary and non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The requested X is not medically necessary. The records show that the patient has already completed X. The X request would exceed the recommended guidelines. In addition, no records have been provided from the treating provider to explain the rationale for the X to explain any extending circumstances which would supersede the recommended guidelines. As such, no new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.
Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**